Practice Transformation Task Force:

CCIP Development

August 26th, 2015

Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Minutes	5 min
4. Purpose of Today's Meeting	5 min
5. Feedback from Health Innovation Steering Committee	20 min
6. Program Design: Complex Patients & Patients with Equity Gaps	30 min
7. Program Design: Community Linkages	20 min
8. Program Design: Monitoring & Reporting Needs	20 min
9. Next Steps	5 min

4. Purpose of Today's Meeting

1. Provide feedback from HISC on CCIP design work to date

2. Obtain feedback and input on design approach and guidelines for CCIP interventions – complete conversation on complex patients and patients with equity gaps

3. Obtain feedback and input on design approach and guidelines for establishing community linkages for all target populations

5. Feedback from HISC

A summary of the CCIP work was presented to the HISC on August 13th. Below is a summary of comments and suggestions for the PTTF to consider.

#	Comment	PTTF To Consider:
1	The approach for all the target patients should be **circular** not linear to convey that someone never "discontinues" from their team	• Revised schematic and language – reviewed on subsequent pages
2	Acknowledge the **overlap between the needs of the target populations** – complex patients may experience gaps in care and patients with equity gaps may have complex needs	• Adding guidelines around cultural competency for complex patients • Benefit to having equity gaps and complex patients remain distinct – reviewed on subsequent pages
3	Understand need to allow for flexibility but consider narrowing definitions in some cases to **better align with CT SIM** ; For instance, the definition of equity gaps	• Defining equity gaps more specifically - reviewed on subsequent pages
4	Want a better understanding of how the **elective capabilities** will fit into the broader programs	• Proposal for how to incorporate elective capabilities – reviewed on subsequent pages
5	When a patient has met their goals and is ready to transition our of one of their respective CCIP program (acknowledging that the individual is not discontinued) consider utilizing a **Peer Support structure** to help patients with this transition.	• Including this role in the recommendations – to be reviewed as part of design process

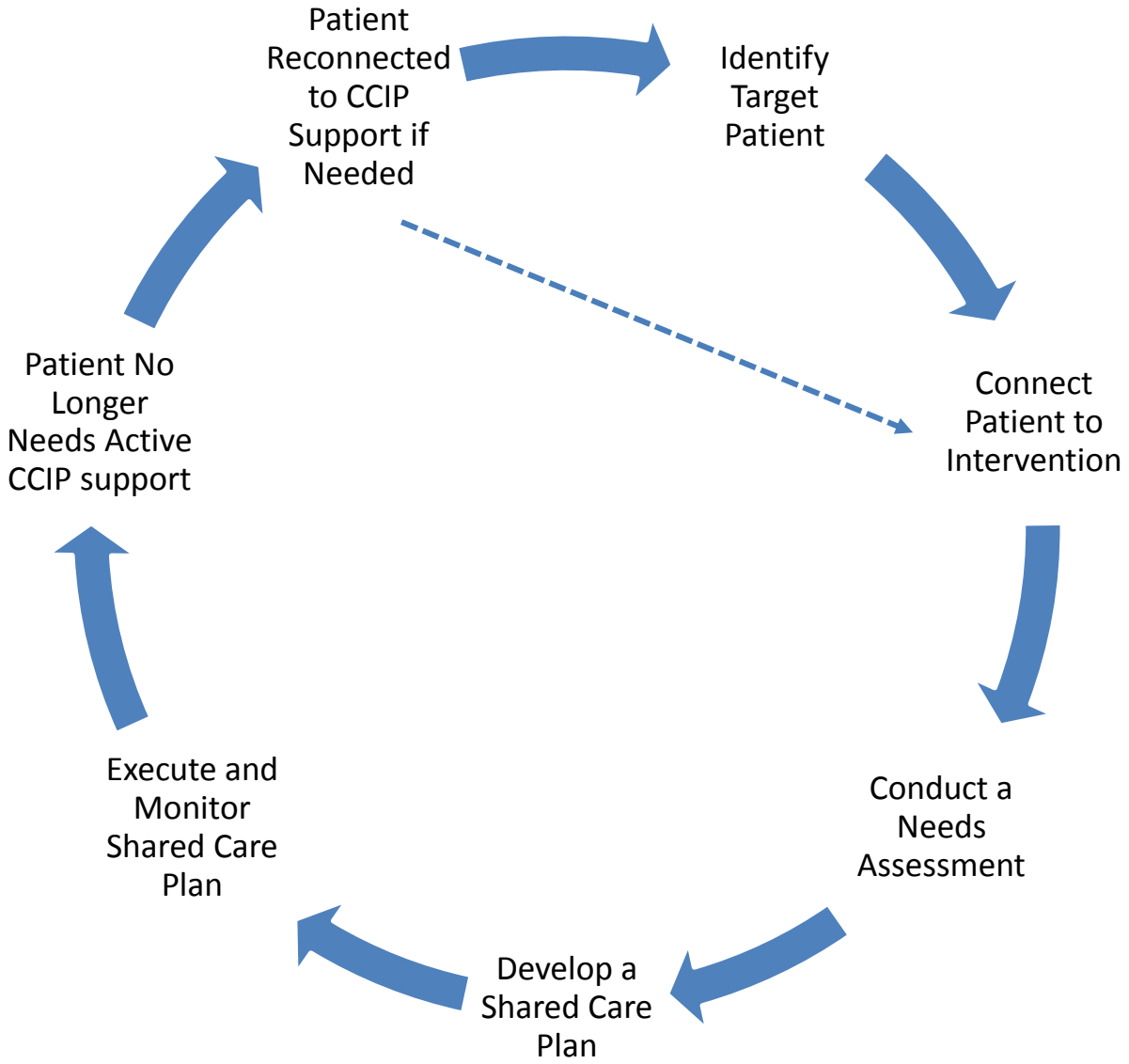
5. Feedback from HISC

A summary of the CCIP work was presented to the HISC on August 13th. Below is a summary of comments and suggestions for the PTTF to consider.

#	Comment	PTTF To Consider:
6	While guidelines should not be overly prescriptive, consider offering guidance or examples of best practices where possible	• Including examples in final report
7	Make sure the needs assessment is comprehensive and considers **barriers to care** as well as social determinants	• When developing needs assessment guidelines – to be reviewed as part of design process
8	**Technology** may not be advanced enough yet for the recommended **target population identification**	• Assessing through Advanced Network/FQHC structured interviews
9	Assess **current state of social services** across Connecticut (where available and what type of services)	• Gathering this information to inform community linkage approach
10	Would like to see framework for the **governance model for community linkages** (i.e.; shared governance)	• Design Group 2's initial thoughts on governance – to be reviewed as part of design process

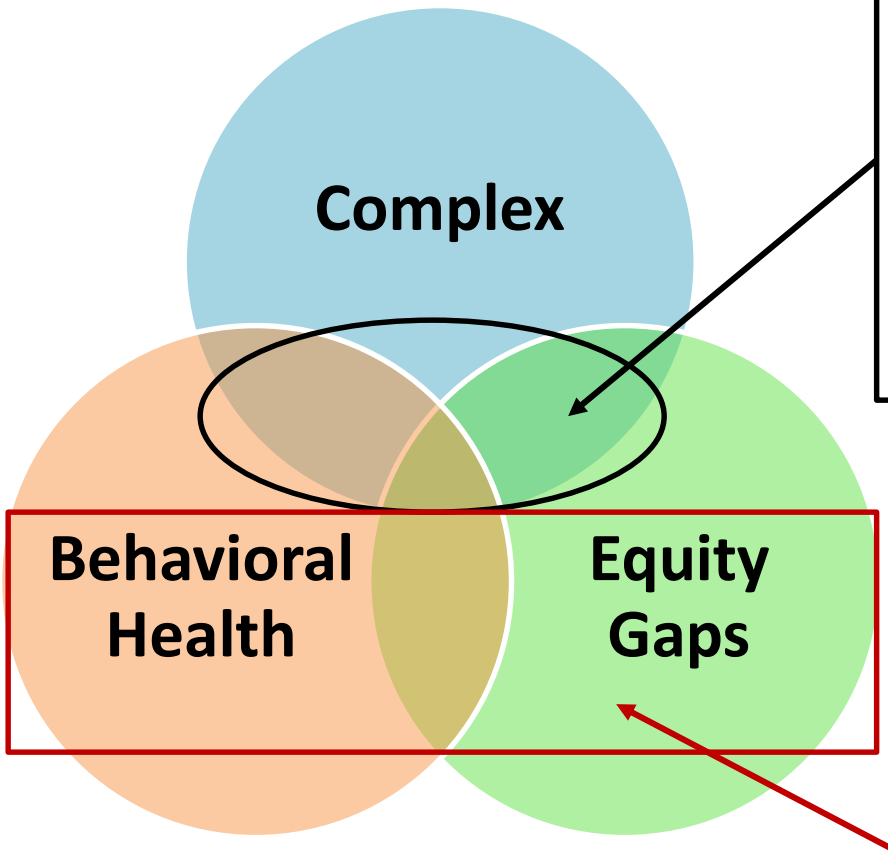
5. Feedback from HISC

We propose the revised process to clarify that when patients transition from active CCIP support, they will still have those services available as needed.



5. Feedback from HISC

The three target populations are not entirely distinct – a patient who is complex can still experience a gap in care and/or will have behavioral health care needs – but, there will still be patients who do not overlap within those categories for whom the interventions should be unique.



Patients Who Are Complex and meet the criteria for the other target populations will:

- Be *defined as complex*
- Care team should be required to *meet CLAS standards* to provide culturally and linguistically competent care to address equity gaps (***new guideline***)
- Have a *behavioral health specialist on the multidisciplinary team* to address mental health needs (***already a guideline)***

Patients Who Are Not Complex:

- Patients will experience equity gaps and/or mild to moderate behavioral health needs who are not complex *will likely not need a full Multidisciplinary team* to address their needs.
- Addressing the needs of these patients is still important and the *interventions for these should be viewed as distinct* from the complex intervention
- As *all patients will be screened for behavioral health*, if a patient with an equity gap has a behavioral health need a referral will be made

5. Feedback from HISC

The HISC appreciated why it was important to allow for flexibility around how networks defined target populations, but expressed that in some cases, like equity gaps, the definition should be more aligned with the broader goals of CT SIM.

Connecticut will establish a whole-person centered healthcare system that will…

- Improve Population Health
- Promote Consumer Engagement
- **Reduce Health Inequities**
- Lower Costs
- Improve access, quality and patient experience

What is CT SIM's definition of equity gaps?

- The Quality Council's Health Equity Design Group is recommending that gaps in care are monitored:
  - For defined sub-populations and a defined set of health outcomes
  - Sub-populations recommended stratification: Black, Latino, and White
  - Health Outcomes stratification: Diabetes, Hypertension, and Asthma

Acknowledging that other equity gaps exist, starting with a definition of equity gaps that is aligned with CT SIM will:

1) Serve as training for networks to learn how to address equity gaps more broadly
2) Align with the financial incentives of the shared savings program

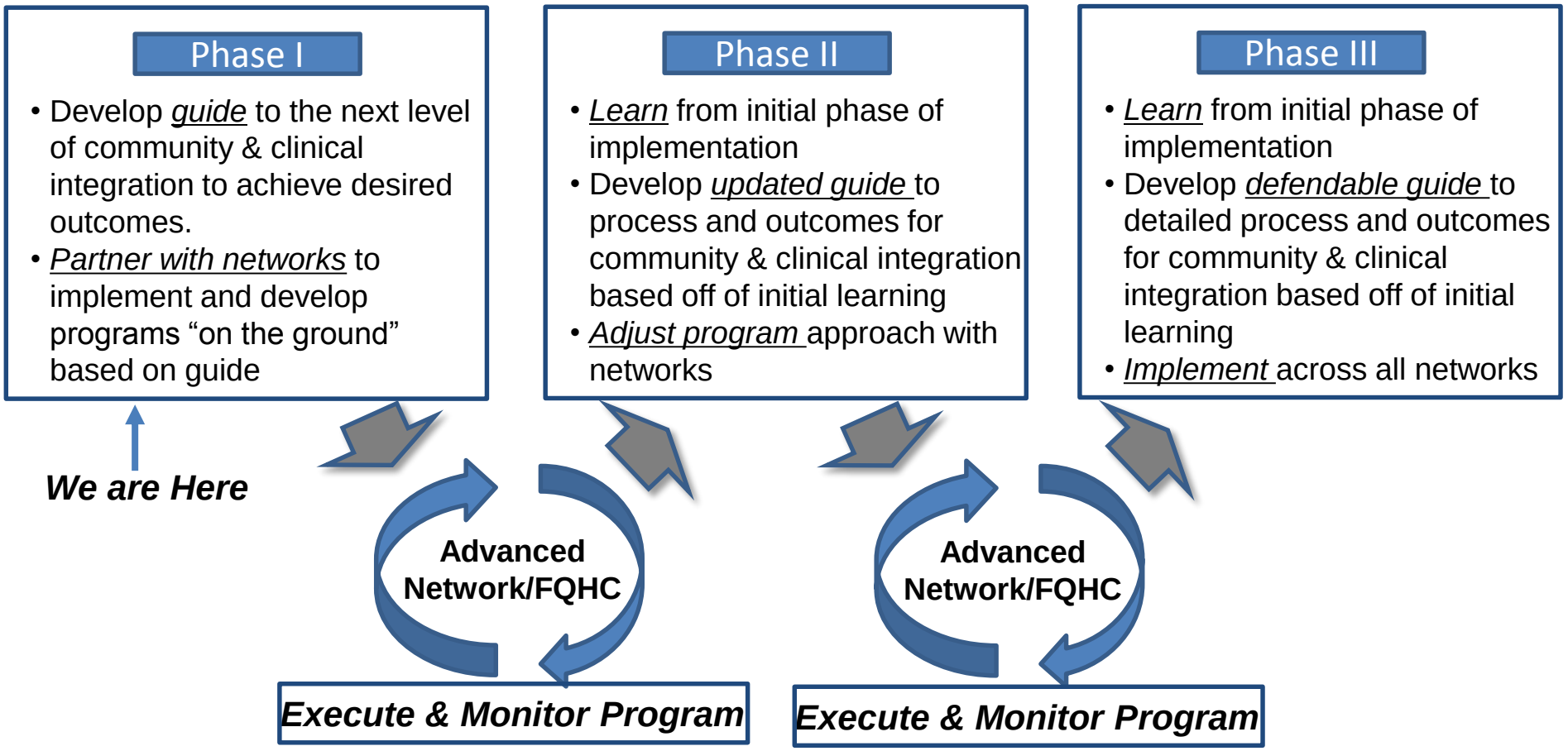
5. Feedback from HISC

The CCIP defined core capabilities are thought to be essential to serving the needs of the target populations, but there will be instances in which networks will identify elective capabilities they believe to be crucial to their target populations needs.

CCIP Elective Capabilities	Examples of Integration into CCIP Programs
Care Transitions	*The network identifies that complex patients have frequent readmissions and wants to implement guidelines for care transitions*
Medication Therapy Management	*Complicated medication regimens are common among target populations and the network wants guidelines for including a pharmacist on the care team*
Oral Health Integration	*The network has many patients with oral health needs and feel they would benefit from better oral health integration*
E-Consults	*Specialty referrals are a challenge for target populations (or more broadly) and networks want to improve specialty consult process*

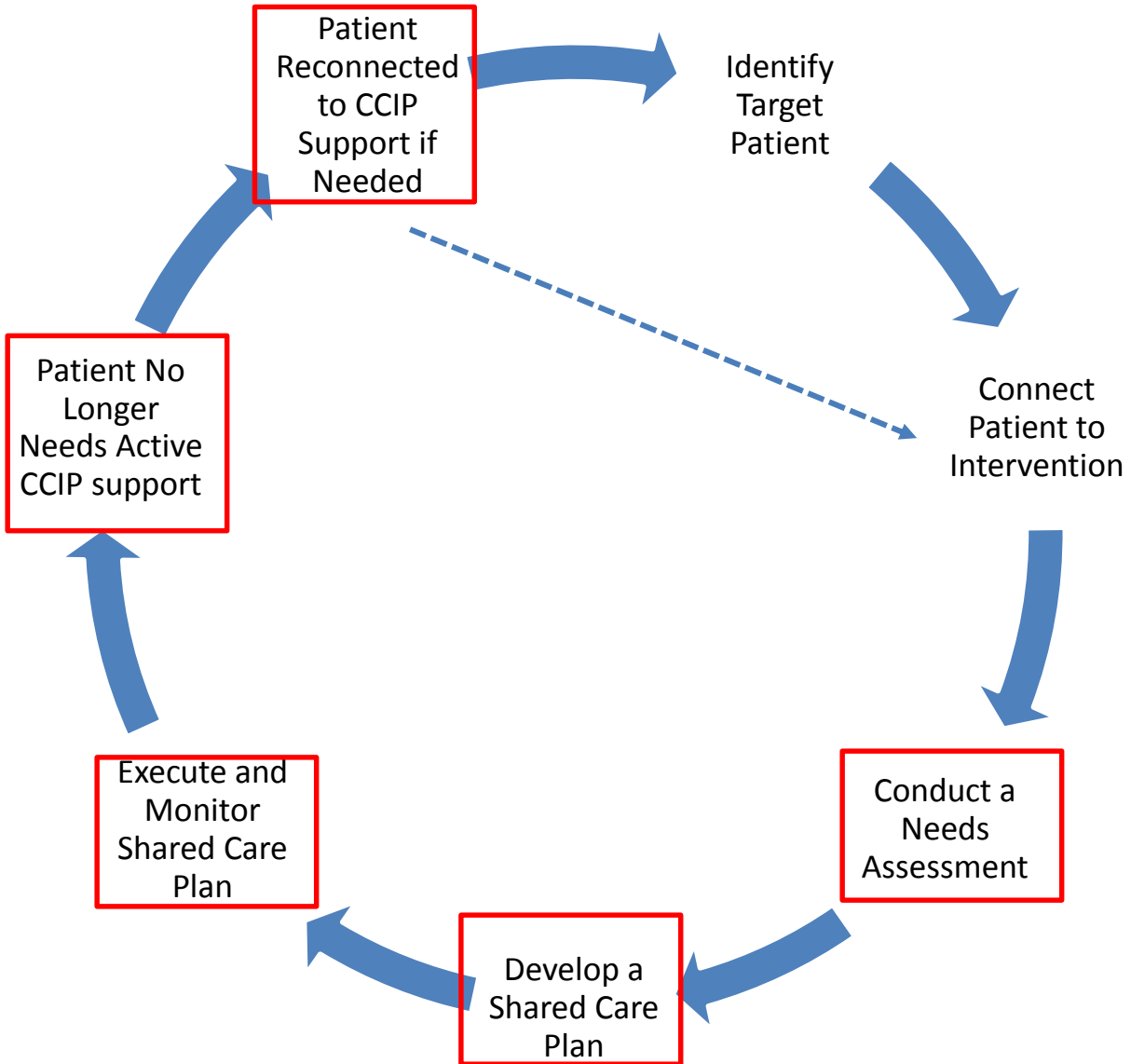
6. CCIP Design Approach

As the PTTF considers recommendations for CCIP design, it should be kept in mind that learning how to best integrate community and clinical services at the network level is an ongoing process. It is an innovation that will require an iterative design process.



6. Program Design: Complex Patients and Equity Gaps

Today the focus will be on completing the conversation on guidelines for the last several CCIP process steps.



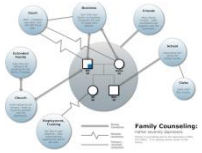
6. Program Design: Complex Patients and Equity Gaps

Crucial to a whole-person centered approach to patient care is a thorough understanding of what has led to the patient's current health care status and the barriers to improving upon their current status. This is of particular importance for patients who are currently not receiving optimal care.

What are the best practices for understanding current needs and assessing a patient's history?

Needs Assessment

- **Clinical**
- **Behavioral**
- **Social** (e.g.; transportation, housing, food, home care needs)



Eco-Map

- **Assessment of all patient supports** (i.e.; every provider who has "touched" the patient – past and present)
- **Synthesizes patient's current state**

Particularly useful for complex patients

6. Program Design: Complex Patients and Equity Gaps

Suggested Guidelines for Discussion	
Complex	**Equity Gaps**
Design a needs assessment tailored toward identifying the needs of complex patients	Design a needs assessment tailored toward patients experiencing gaps in care

• The needs assessment should include:
  • A historical assessment of the patient's needs, which is commonly assessed through an eco-map
  • A current assessment of clinical, social and behavioral needs that also identifies current barriers to receiving necessary care. Consider the following categories for the needs assessment:
  • Clinical: identifying the primary/secondary diagnoses driving the needed care
  • Behavioral: mental health, substance abuse, and trauma
  • Social: family/social/cultural characteristics and preferences, communication needs (including language needs), behaviors affecting health, assessment of health literacy, barriers to care (transportation, food/nutrition, housing, employment status, legal concerns, etc.)
	• The needs assessment should include:
	  • The needs assessment should focus on behavioral and social need that are impacting the clinical area in which the AN/FQHC has identified an equity gap. Consider the following categories for the needs assessment:
	  • Clinical: current clinical needs related to equity gap
	  • Behavioral: mental health, substance abuse, and trauma
	  • Social: family/social/cultural characteristics and preferences, communication needs (including language needs), behaviors affecting health, assessment of health literacy, barriers to care (transportation, food/nutrition, housing, employment status, legal concerns, etc.)

6. Program Design: Complex Patients and Equity Gaps

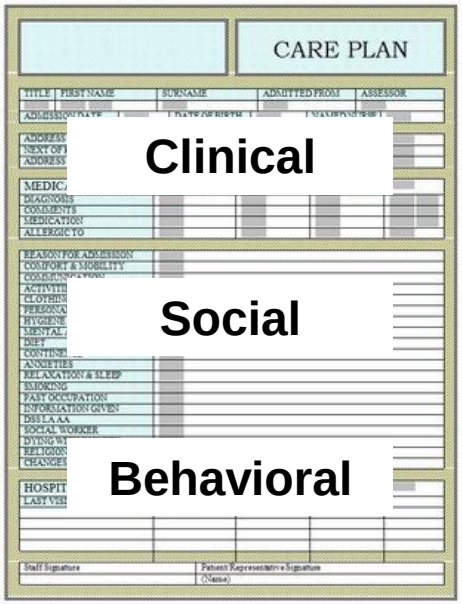
Suggested Guidelines for Discussion	
Complex	**Equity Gaps**
Define the processes and protocols to conduct the needs assessment	Define the processes and protocols to conduct the needs assessment

• The needs assessment should require the patient's input and identify what the patient feels most challenged by in relation to their healthcare
• The network processes and protocols should identify:
  • **Who** oversees the administration of the needs assessment and the individual(s) responsible for the different sections
  • **Where** the assessment should be conducted. Consider the patient's home or the point of enrollment (location will depend on enrollment process)
  • **When** the assessment will be conducted. Consider setting a timeframe within which the assessment has to occur post enrollment (e.g.; one week)
  • **How** assessment is completed. Consider whether or not the presence of all individuals responsible for filling it out is required or if it can be completed in a piecemeal fashion as long as it is done in a defined timeframe and includes the patient
	• The needs assessment should require the patient's input and identify what the patient feels most challenged by in relation to the clinical area in which there is a gap in care
	• The network processes and protocols should identify:
	  • **Who** oversees the administration of the needs assessment, for equity gaps this is commonly the CHW
	  • **Where** the assessment should be conducted. This is commonly done in the patient's home
	  • **When** the assessment will be conducted. Consider setting a timeframe within which the assessment has to occur post enrollment (e.g.; one week)

6. Program Design: Complex Patients and Equity Gaps

Developing treatment goals for the patient that are informed by the needs assessment will support care improvement.

What are the best practices for setting and monitoring care goals for patients?



Design Questions	Best Practice
What should the care plan include?	• Care plan should reflect the needs assessment and eco-map (in the case of complex patients) • Care plan should clearly state treatment goals and the associated timeframe for completion
Who should complete the care plan?	• Patient centered care plan that is developed with the patient and family present and with input from all care providers (identified by eco-map). • Ideal situation is to do a case conference with the patient and all providers to set treatment goals for next 3-6 months and identify who is responsible for working with the patient on each goal

6. Program Design: Complex Patients and Equity Gaps

Suggested Guidelines for Discussion	
Complex	**Equity Gaps**
Design a shared care plan that reflects the patient's input and needs identified through the needs assessment	Design a shared care plan that reflects the patient's input and needs identified through the needs assessment

• The care plan should be patient centered and the patient should be actively involved in its development. Consider allowing the patient to identify areas of focus based on what they feel to be their biggest needs
• The care plan should include clinical, behavioral health, and social health goals. Consider the following topics within these sections:
  • Clinical Goals: primary/secondary driving diagnoses, medication reconciliation, nutrition needs, Durable Medical Equipment (DME) needs, Coordination of ongoing care needs
  • Behavioral Health Goals: Depression, Substance Abuse, Pain
  • Social Health Goals: Housing, Income/Finance, Transportation, Self-Management, Necessary paper work (state IDs, legal paper work, power of attorney, etc.)
• Each care plan goal should have associated action steps and a due date. The date completed and days since intervention should also be tracked
	• The care plan should be patient centered and the patient should be actively involved in its development. Consider allowing the patient to identify areas of focus based on what they feel to be their biggest needs
	• The care plan should include clinical, behavioral health, and social health goals. Consider the following topics within these sections:
	  • Clinical Goals: clinical improvement needed to close equity gap, medication reconciliation, nutrition needs, Durable Medical Equipment (DME) needs,
	  • Behavioral Health Goals: Depression, Substance Abuse, Pain
	  • Social Health Goals: Housing, Income/Finance, Transportation, Self-Management, Necessary paper work (state IDs, legal paper work, power of attorney, etc.)
	• Each care plan goal should have associated action steps and a due date. The date completed and days since intervention should also be tracked

6. Program Design: Complex Patients and Equity Gaps

Suggested Guidelines for Discussion	
Complex	**Equity Gaps**
Define the processes and protocols to create the shared care plan	Define the processes and protocols to create the shared care plan

• The care plan should be owned and completed by the multidisciplinary care team and require the patient's input
• The network processes and protocols should identify:
  • **Who** oversees the development of the care plan and the individual(s) responsible for managing the to the goals in the different sections
  • **Where** the care plan is created. Consider the patient's home or in the primary care setting
  • **When** the care plan will be completed by. Consider setting a timeframe within which the care plane has to be completed (e.g.; one week)
  • **How** the care plan is completed. Consider whether or not the presence of all individuals responsible for filling it out is required or if it can be completed in a piecemeal fashion as long as it is done in a defined timeframe and includes the patient
	• The care plan should be owned and completed by the CHW and require the patient's input
	• The network processes and protocols should identify:
	  • **Who** oversees the administration of the care plan, for equity gaps this is commonly the CHW
	  • **Where** the care plan should be completed. This is commonly done in the patient's home
	  • **When** the care plan will be completed by. Consider setting a timeframe within which the care plane has to be completed (e.g.; one week)

6. Program Design: Complex Patients and Equity Gaps

Once the shared care plan is developed, successful execution will require efficient communication with the patient and among the care team members (who will often work out of different locations and organizations).

What are the best practices for communication with the patient and the care team?

Care Team Meetings

Do these meetings have to occur in person?

How frequently should they occur?

What should be discussed at these meetings?

Patient Progress Update Visits

Where should these meetings occur?

How frequently should they occur?

How/where are outcomes of these meetings documented?

Information Sharing

How is information shared/made available electronically to all relevant providers (care team and community partners)?

Where are updates/progress notes to the care plan documented?

6. Program Design: Complex Patients and Equity Gaps

Suggested Guidelines for Discussion	
Complex	**Equity Gaps**
Define the processes and protocols for care team meetings to discuss complex patients	Define the processes and protocols for care team meetings to discuss patients with equity gaps
• The network processes and protocols should identify: • **Frequency** of care team meetings (***should PTTF recommend a minimum standard?***) • **Where/How** the meetings should occur – in person, via conference call, primary care clinic, hospital, etc. • **Who** is required to attend the care team meetings • **Standardized reporting structure** for patient report outs that identifies what information should be shared on newly enrolled patients, patients actively in the program, and graduated patients (see Camden Coalition example)	• The network processes and protocols should identify: • **Frequency** of care team meetings (***should PTTF recommend a minimum standard?***) • **Where/How** the meetings should occur – in person, via conference call, primary care clinic, hospital, etc. • **Who** is required to attend the care team meetings outside of the CHW. Consider primary care team representation • **Standardized reporting structure** for patient report outs that identifies what information should be shared for newly enrolled patients, patients actively in the program, and graduated patients (see Camden Coalition example)

6. Program Design: Complex Patients and Equity Gaps

Suggested Guidelines for Discussion	
Complex	**Equity Gaps**
Define processes and protocols for monitoring patient progress on the care plan	Define processes and protocols for monitoring patient progress on the care plan
• The network processes and protocols should: • **Define** the key in person touch points with the patient (e.g.; follow up with patient in 30, 60, and 90 days post intervention) and the objective of each encounter • **Establish** which care team members have to be involved in those touch points • **Develop** a standardized progress note to document what occurred during the established touch points as well as a standardized tool to track patient encounters that occurred outside the key touch points. The standardized progress note should reflect the objectives and outcome of the visit • **Establish** process to reassess needs and care plan if treatment goals are not being met along established timelines	• The network processes and protocols should: • **Define** the key in person touch points with the patient (e.g.; follow up with patient in 30, 60, and 90 days post intervention) and the objective of each encounter • **Establish** who needs to participate in the care team meeting other than the CHW at each touch point • **Develop** a standardized progress note to document what occurred during the established touch points as well as a standardized tool to track patient encounters that occurred outside the key touch points. The standardized progress note should reflect the objectives and outcome of the visit • **Establish** process to reassess needs and care plan if treatment goals are not being met along established timelines

6. Program Design: Complex Patients and Equity Gaps

Suggested Guidelines for Discussion	
Complex	**Equity Gaps**
The organization has a documented process for exchanging health information across care settings which includes:	The organization has a documented process for exchanging health information across care settings which includes:

• An agreement with care providers about exchanging information
  • Identify all individuals/entities outside of the network with which information will need to be exchanged
  • Execute a Business Associates Agreements (BAA) with all identified individuals/entities [***recommended by design group two]***
  • An alternative process to share information if information needs to be exchanged with an entity for which there is no BAA (e.g.; Release of Information)
• The type of information to be exchanged
  • Specify which information needs to be shared with different individuals/entities
  • At a minimum the individuals/entities who need access to the needs assessment, care plan, and progress notes should be explicitly identified and these items should be made available to them
	• An agreement with care providers about exchanging information
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	  • Execute a Business Associates Agreements (BAA) with all identified individuals/entities [***recommended by design group two]***
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6. Program Design: Complex Patients and Equity Gaps

Suggested Guidelines for Discussion	
Complex	**Equity Gaps**
The organization has a documented process for exchanging health information across care settings which includes:	The organization has a documented process for exchanging health information across care settings which includes:

• Time frames for exchanging information
  • Pending understanding of current technology, near real time notifications of updates to the care plan and creation of progress notes [***too prescriptive?]***
  • Care plans, needs assessments, and progress notes should be stored electronically in a place where all individuals/entities identified to need access have access
• How the organization facilitates referrals
  • Identify member of the multidisciplinary care team whose responsibility it is to track patient referrals
  • Develop process to ensure the referral was completed and the necessary information is transmitted back to the primary care team and the multidisciplinary care team
	• Time frames for exchanging information
	  • Pending understanding of current technology, near real time notifications of updates to the care plan and creation of progress notes [***too prescriptive?]***
	  • Care plans, needs assessments, and progress notes should be stored electronically in a place where all individuals/entities identified to need access have access
	• How the organization facilitates referrals
	  • Identify member of the multidisciplinary care team whose responsibility it is to track patient referrals
	  • Develop process to ensure the referral was completed and the necessary information is transmitted back to the primary care team and the multidisciplinary care team

6. Program Design: Complex Patients and Equity Gaps

The ultimate goal of is to improve each patient's current circumstances through patient education and effective self-management. Once this is accomplished, the patient likely will need less care management and achieve better outcomes

How will the network know when the patient has developed the necessary skills?

Through working with the multidisciplinary care team the complex patients will have…

- ✓ Been connected to needed social support services
- ✓ Engaged in his/her health care
- ✓ Developed self-management skills
- ✓ Achieved their goals on the shared care plan

Through working with a CHW patients with equity gaps will have….

- ✓ Been connected to needed social support services
- ✓ Barriers to care have been addressed (e.g.; health literacy, culturally competent education, etc.)
- ✓ Developed self-management skills
- ✓ Achieved their goals on the shared care plan

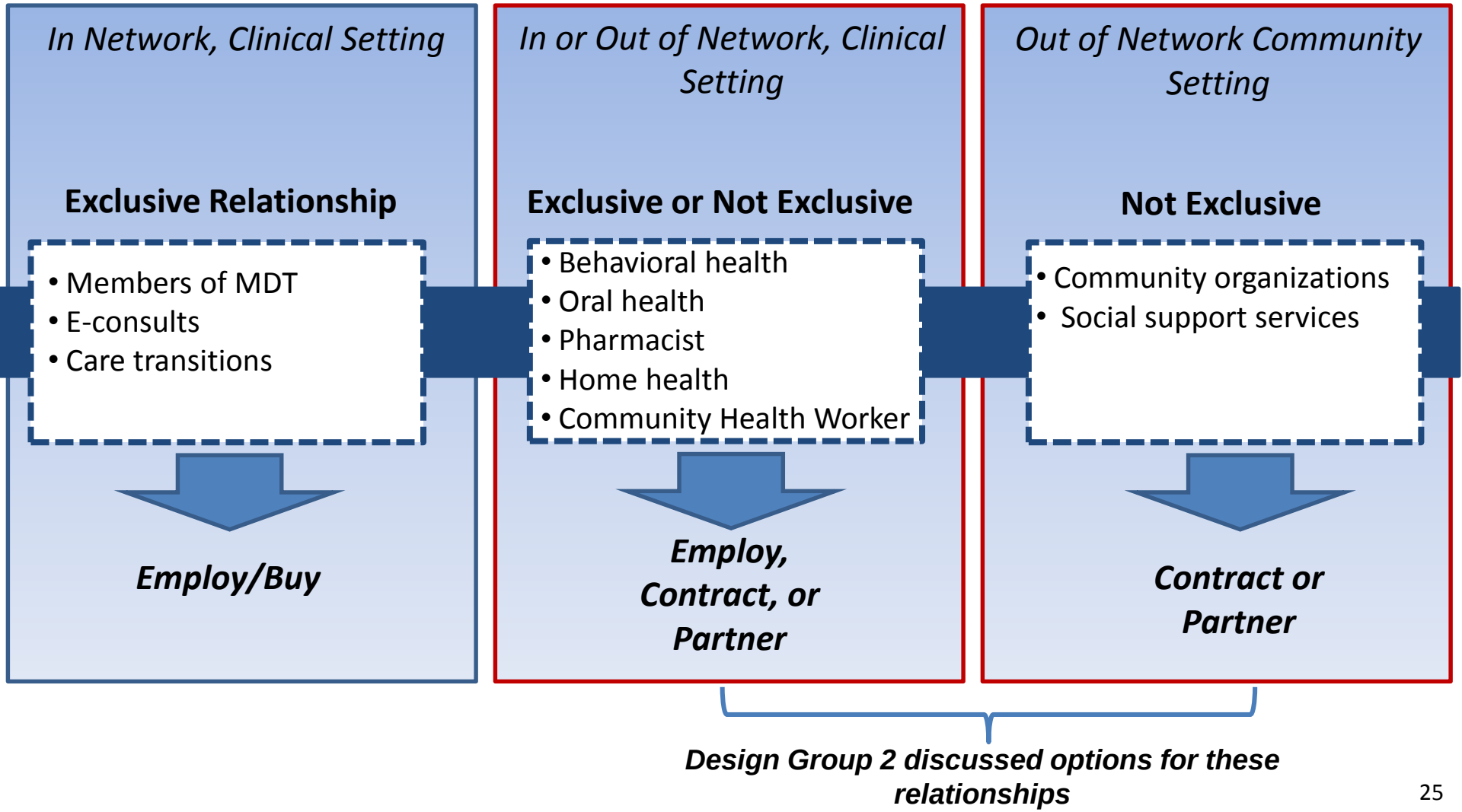
Develop an assessment to determine if patient is ready to manage their care more independently

6. Program Design: Complex Patients and Equity Gaps

Suggested Guidelines for Discussion	
Complex	**Equity Gaps**
Develop or identify existing criteria to evaluate the patient's readiness to graduate from complex care management program	Develop or identify existing criteria to evaluate when the patient has acquired necessary education and self-management skills to graduate from working with the CHW
• Identify assessment that evaluates the patient's ability to self-manage (e.g.; The Client Perception of Care Questionnaire-CPCQ) • Make transitional support available to the patient as needed. Consider connecting the patient to a Peer Support to provide assistance as needed after graduation from complex care management • Process to identify when graduated patient is in crisis and needs to be reconnected to the multidisciplinary team	• Identify assessment that evaluates the patients ability to self-manage (e.g.; The Client Perception of Care Questionnaire-CPCQ) • The health outcome for which the equity gap was identified has improved [***specify that it has to be on par with comparison groups?***] • Process to identify when graduated patient needs to reconnect with CHW for care management/educational support

7. Program Design: Community Linkages

Design Group Two explored how the exclusivity and community based nature of linkages might impact the type of governance and agreements pursued.

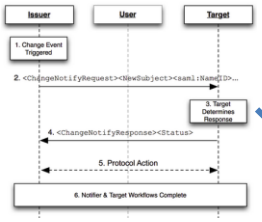


7. Program Design: Community Linkages

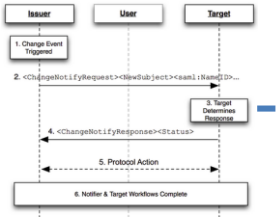
Community facing services (e.g.; social services) will likely not be owned by the network and in many geographic areas there will be multiple networks but only one provider per needed social service.

7. Program Design: Community Linkages

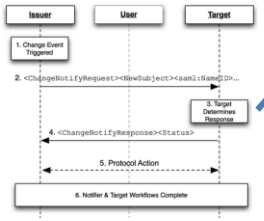
Having networks develop unique protocols and processes to interact with community resources that have to be shared, may present unintended barriers to community and clinical integration.



Protocol A



Protocol B



Protocol C

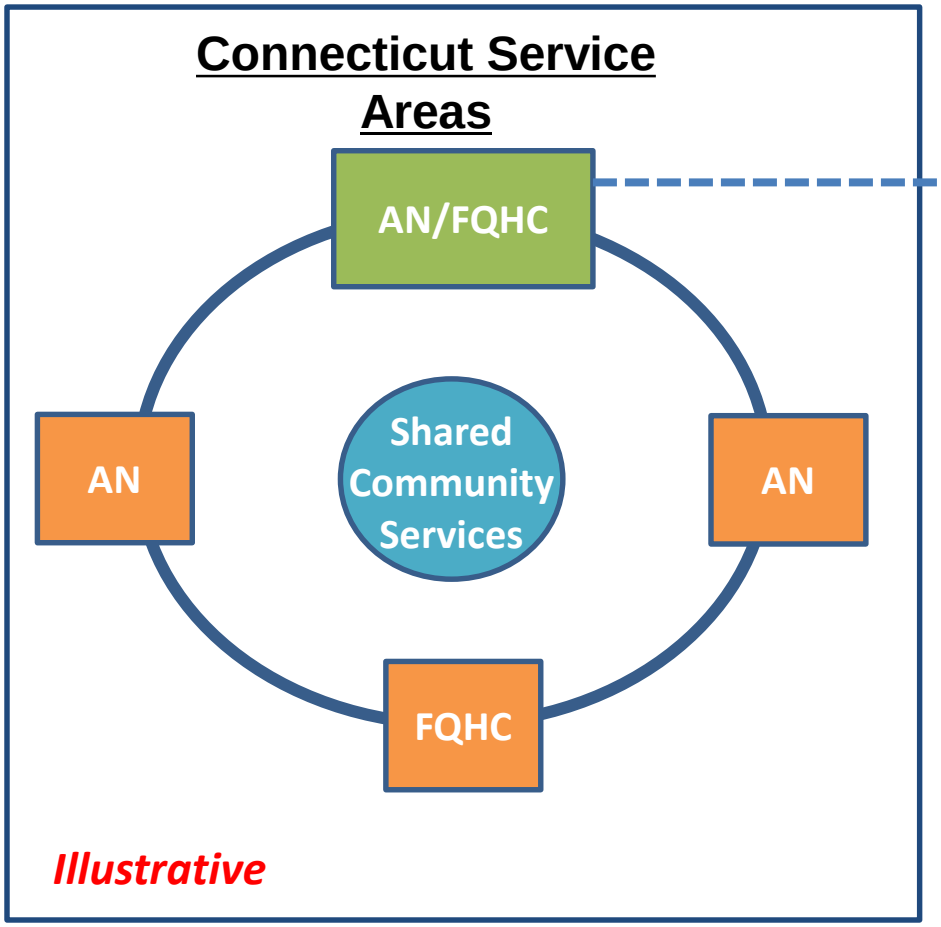
Local Community Organizations/ Social Services

Potential Barriers

- Inefficiencies: community organization will have to manage to multiple protocols and processes
- Technology: independent development of relationships may lead to use of multiple technological solutions for communication **[Design Group 3 to discuss benefit of a standardized solution]**
- Network Bias: community organizations may work more closely with one organization over another if processes and protocols are easier to follow leading to potential equity and access issues for patients

7. Program Design: Community Linkages

Given the geographic overlap of networks in Connecticut, the group considered the idea of shared governance for clinical-community relationships within defined service areas.



Who should be the convener to develop the governance over shared resources?

Leadership Team

Develops leadership team (governance) for shared services that **has partners and representation across the continuum of health, community-based care**, **organizations that address social determinants of health, and consumer/ patient** representation.

What services should be considered shared resources?

- Housing
- Food
- Income
- Transportation
- Utilities

CT 2-1-1 provides information about many community/social services focused on supporting emergent needs, on-going needs, and providing education/guidance

7. Program Design: Community Linkages

If shared governance is the approach pursued for community linkages, it will not be specific to the target populations.

Design Group Two Agreed That:

- Shared governance is the correct approach
- An Advanced Network of FQHC should not be the convener in order to avoid unhealthy competition between the networks
- In addition to identifying the processes for linking patients to community resources, there should be outcomes oriented accountability for all organizations participating in shared governance structure

Pending Design Questions:

- Who should be the convener to establish shared governance?
- If the convener is not an Advanced Network or FQHC how would establishing a convener be incorporated into the MQISSP RFP process?
- How should the service areas for shared governance be established?
- How will participating entities be held accountable? Through CCIP scorecard?

7. Program Design: Community Linkages

The agreement and governance for non-exclusive relationships that are not community-centric will likely vary depending on what service is being provided and how it influences the potential value of the relationship.

Informal **Governance** *Formal*

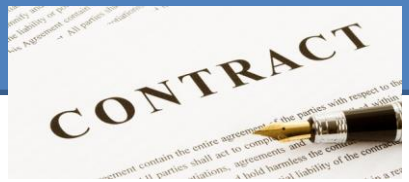
Taskforce ***Formal Board with Bylaws*** ***Joint Oversight By One Member from Each Entity***

Agreement

Handshake

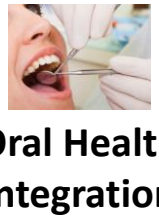
VNAA
Home Health

MOU



Contractual Arrangement

Illustrative



Oral Health Integration

Behavioral Health Integration

Medication Therapy Management

7. Program Design: Community Linkages

Design Group Two also considered how non-exclusive, clinically focused relationships should be developed.

Design Group Two Agreed That:

- At a minimum all networks should have a protocol in place for communication with non-exclusive partners
- There should be an identified mechanism for outcomes oriented accountability for non-exclusive partners

The Behavioral Health Design Group is Considering:

- A minimum standard of an MOU between networks and behavioral health specialists

Pending Design Questions:

- Comfortable requiring an MOU for behavioral health integration?
- Is an MOU necessary for other non-exclusive relationships?
- How will non-exclusive entities be held accountable? Through CCIP scorecard?

8. Program Design: Monitoring & Reporting

For each CCIP intervention process and outcome metrics will be identified. The purpose of developing these metrics will enable networks to: 1) Evaluate whether or not the interventions are successfully meeting the CT SIM/CCIP objectives; 2) Identify opportunities for quality and process improvement; and 3) Promote accountability for patient care across all stakeholders

CCIP Performance Dashboard/Scorecard

Objective	How To Meet
1) Meeting CT SIM/CCIP Objectives	• Define CCIP process and outcome metrics – PTTF? Network? • Define which CT SIM metrics are relevant for each interventions • Method to monitor process/outcomes only for patients in intervention
2) Identify quality improvement opportunities	• Regularly monitor CCIP performance through use of a dashboard/scorecard • Identify individual(s) responsible for review and identification of improvement opportunities
3) Accountability across stakeholders	• Forum for sharing performance across all stakeholders – publicly made available? Reviewed at monthly meetings? • Define stakeholder expectations: which metrics are stakeholders responsible for?

8. Program Design: Monitoring & Reporting

Suggested Guidelines for Discussion	
Complex	**Equity Gaps**
Establish method to report on complex care management performance	Establish method to report on equity gap performance

• The goals of networks monitoring and reporting on performance include enabling them to:
  • Evaluate whether or not interventions are successfully meeting the CT SIM/CCIP objectives. This will require:
  • Tracking aggregate costs/utilization; a standard set of quality metrics [***define these for complex patients to align with scorecard***]; and, patient satisfaction for patients receiving complex care management prior to the CCIP intervention and post intervention
  • Process to analyze/stratify data only for patients in the intervention
	• The goals of networks monitoring and reporting on performance include enabling them to:
	  • Evaluate whether or not interventions are successfully meeting the CT SIM/CCIP objectives. This will require:
	  • Tracking aggregate costs/utilization; a standard set of quality metrics [***define these based on disease state for which there is an equity gap***]; and, patient satisfaction for patients receiving support from a CHW to address a gap in care prior to the CCIP intervention and post intervention
	  • Process to analyze/stratify data only for patients in the intervention

8. Program Design: Monitoring & Reporting

Suggested Guidelines for Discussion	
Complex	**Equity Gaps**
Establish method to report on complex care management performance	Establish method to report on equity gap performance

• Identify opportunities for quality and process improvement. This will require:
  • Defining process metrics for the intervention
  • Establishing a dashboard or scorecard to regularly monitor the complex care management intervention performance
  • Identifying an individual(s) responsible for creating the dashboard, and reviewing and identifying improvement opportunities
• Promote accountability for patient care across all stakeholders. This will require:
  • Identifying a forum to share performance across all stakeholders (e.g.; share publicly, monthly meetings with stakeholders, etc.)
  • Defining various stakeholder expectations (i.e.; are there specific metrics individual stakeholders are responsible for)
	• Identify opportunities for quality and process improvement. This will require:
	  • Defining process metrics for the intervention
	  • Establishing a dashboard or scorecard to regularly monitor the equity gap intervention performance
	  • Identifying an individual(s) responsible for creating the dashboard, and reviewing and identifying improvement opportunities
	• Promote accountability for patient care across all stakeholders. This will require:
	  • Identifying a forum to share performance across all stakeholders (e.g.; share publicly, monthly meetings with stakeholders, etc.)
	  • Defining various stakeholder expectations (i.e.; are there specific metrics individual stakeholders are responsible for)

8. Next Steps

- Distribute summary of guidelines discussed and the status of PTTF consensus on guidelines
- Continue to develop elective capabilities offline
- Interview Advanced Networks and FQHCs about the current state of their technology to inform potential HIT solutions for CCIP
- Test CCIP programs with CHW association
- Present CCIP work to MAPOC CMC on September 9th

9. Appendix: Index of Acronyms

Acronym	Acronym Defined
ACO	Accountable Care Organization
AMH	Advanced Medical Home
AN	Advanced Network
BAA	Business Associates Agreement
CCIP	Community and Clinical Integration Program
CHT	Community Health Team
CHW	Community Health Worker
EHR/EMR	Electronic Health Record/Electronic Medical Record
FQHC	Federally Qualified Health Center
MAPOC CMC	Council on Medical Assistance Program Oversight - Care Management Committee
MOU	Memorandum of Understanding
MQISSP	Medicaid Quality Improvement Shared Savings Program
OMB	Office of Management and Budget
OMH	Office of Minority Health
PCMH	Patient Centered Medical Home
PM	Program Manager
POC	Plan of Care
PTTF	Practice Transformation Taskforce
SIM	State Innovation Model
VBID	Value Based Insurance Design
VNAA	Visiting Nurse Associations of America